OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Rhonda Mann aka Jordan Mann	**10/08/68**	**147-78-1209**
Patient Address: **80 ST. NICHOLAS AVE, NEW YORK, NY 10026**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Retha Buck, 1 University Place, NY, NY 10003

8. Name and address of person(s) or category of person to whom this information will be sent:
Deborah Martin Norcross, 60 Marion Road West, Princeton, NJ 08540

9(a). Specific information to be released:

☑ Medical Record from (insert date) **6/01/2006** to (insert date) **Present**

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Legal Matter**	**End of litigation**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Sworn to before me this 9th day of NOVEMBER 2008

Rhonda Mann

Signature of patient or representative authorized by law.

Date: _____

Notary Public, State of New York
No. 02UM6132601
Qualified in Kings County
Commission Expires Sept. 19, [illegible]

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Rhonda Mann aka Jordan Mann	**10/08/68**	**147-78-1209**

Patient Address: **80 ST. NICHOLAS AVE, NEW YORK, NY 10026**

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
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4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Ann Boris, St. Luke's Roosevelt Hospital, Outpatient Clinic, 1000 Tenth Avenue, NY, NY 10019

8. Name and address of person(s) or category of person to whom this information will be sent:
Deborah Martin Norcross, 60 Marion Road West, Princeton, NJ 08540

9(a). Specific information to be released:

☑ Medical Record from (insert date) **6/01/2006** to (insert date) **Present**

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

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_____ **Mental Health Information**

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Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Legal Matter**	**End of litigation**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Rhonda Mann

Signature of patient or representative authorized by law.

Date: Sworn to before me this 4th day of [illegible]

Notary Public, State of New York
No. 02UM6132601
Qualified in Kings County
Commission Expires Sept. 19, 2009

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

Jordan Mann, Plaintiff, v. Plus One Fitness; Trump World Towers; "Robert" Doc; Jamie MacDonald; Does 1 – 10 inclusive, Defendant(s).	)	CIVIL ACTION NO. 07-CV-5691 (NRB/DF) BENEFITS RECORDS AUTHORIZATIONS

To: New York State Department of Labor
PO Box 15130
Albany, NY 12212

RE: JORDAN MANN, formerly known as RHONDA MANN
Case/File Reference No.:

You are hereby authorized to release and furnish to the law firm of Martin Norcross, LLC, c/o Deborah Martin Norcross, attorneys of record for Defendants, complete copies of any and all benefit applications, records, doctors' reports, correspondence, notes, memoranda, invoices and all other documents of any nature that identify or in any way relate to the Workers' Compensation Unemployment Insurance Benefit/ Disability Benefits/Social Security/ Welfare and/or other Benefit claim that was filed by or on behalf of RHONDA MANN and any and all benefits paid to RHONDA MANN pursuant to such a benefit claim.

Rhonda Mann
RHONDA MANN
Social Security No.:147-78-1209

Sworn to before me this
4th day of August 2008

[illegible] UMOH
Notary Public, State of New York
No. 02UM6132601
Qualified in Kings County
Commission Expires Sept. 19, 2009

Form **4506**

(Rev. January 2008)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**

▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T,** Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
Rhonda Mann	**147-78-1209**
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

Jordan Mann, 210 Pale San Vitores Road, PO Box 9370, Tamuning, Guam 96931

4 Previous address shown on the last return filed if different from line 3

80 St. Nicholas Ave, NY, NY 10026

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Deborah Martin Norcross, Martin Norcross, LLC, 60 Marion Road West, Princeton, NJ 08545

Caution: ***DO NOT SIGN*** *this form if a third party requires you to complete Form 4506, and lines 6 and 7 are blank.*

6 **Tax return requested.** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ **1040**

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☑

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

01 / 01 / 2006	**01 / 01 / 2007**	/ /	/ /
/ /	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ **39.00**
b	Number of returns requested on line 7	**1**
c	Total cost. Multiply line 8a by line 8b	$ **39.00**

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☑

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here

Rhonda Mann — 8/4/08
Signature (see instructions) — **Date**

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature — **Date**

Telephone number of taxpayer on line 1a or 2a
(671) 646-9171

Sworn to before me This 4th day of August 2008
NKEREUWEM UMOH
Notary Public, State of New York
No. 02UM6132601
Qualified in Kings County
Commission Expires Sept. 19, 2009

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 41721E **Form 4506** (Rev. 1-2008)